

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036605

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 150 Primary Registration District No. 4240 Registrar's No. 55

FILED OCT 10 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) Blue Springs		c. CITY OR TOWN Blue Springs	
Length of stay in 1b 5 months		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 520 Lakeview		d. STREET ADDRESS (If outside, give location) 520 - Lakeside	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Samuel Burford Crank			4. DATE OF DEATH Month Day Year 10 1 63		
5. SEX male	6. COLOR OR RACE Wht	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-31-84	9. AGE (last birthday) 79	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (City and state or country) Logan County Ark U.S.	
13a. FATHER'S NAME Crank		13b. MOTHER'S MAIDEN NAME Martha		14. NAME OF HUSBAND OR WIFE Ella Crank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. [redacted]		
17. INFORMANT Address Ella Crank 520 Lakeview					

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthmaticus DUE TO (b) Pulmonary Embolism DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 mos
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from 9/29/63 to 10/1/63 and last saw him alive on 10/1/63.
Death occurred at 3:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. H. E. M. D.		22b. ADDRESS 808 So 15 Blue Springs, Mo		22c. DATE SIGNED 10/1/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-1-63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION City, town, or county Tulsa, Okla.	(State)
24. FUNERAL DIRECTOR Mayfield Blue Springs Mo		25. DATE RECD. BY LOCAL REG. 10-1-63	26. REGISTRAR'S SIGNATURE W. B. Longford	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

ITEM NO.

VS 300
Rev. 4/59
1 7001
2 7001
3 2
4 0
5 1
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7 1
8 2
9 527.1
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11
12 90-0
13 20

OCT 29 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Charles E. Mayfield

Licensed Embalmer No. *4638*

P. O. Address

Blue Springs,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.